☐ CHECK HERE IF THIS IS A CHANGE OF HEALTH PLAN
ENTIRE FORM MUST BE COMPLETED

HANFORD EMPLOYEE WELFARE TRUST (HEWT)
MEDICAL/DENTAL ENROLLMENT FORM

EFFECTIVE DATE:

LAST NAME	FIRST NAME	M.I.	PR NO.	SSN	BIRTHDATE (MO/DAY/YR)

MAILING ADDRESS	MSIN	HOME PHONE	WORK PHONE
		( )	( )

CITY, STATE, ZIP

CHECK ONE: ◯ ACTIVE ◯ RETIRED ◯ LTD ◯ COBRA ◯ OTHER: _____

COMPANY: ◯ FH ◯ CH2M ◯ NHC ◯ Duratek ◯ JCI ◯ ENW ◯ Parsons ◯ ATL ◯ _____

ACTIVE EMPLOYEE MEDICAL PLAN:
◯ UHC PPO-N
◯ Group Health Options Point-of-Service

RETIREE MEDICAL PLAN:
◯ UnitedHealthcare ◯ Waive Coverage
◯ Group Health Options Point-of-Service

Benefits Administration Use

LEVEL OF COVERAGE: ◯ Waive Coverage ◯ Self Only ◯ Self + One ◯ Self + More Than One

Covered Under HEWT Spouse? ◯ Yes ◯ No Spouse SSN _____

ACTIVE EMPLOYEE DENTAL PLAN:
◯ CIGNA Dental Assistance
◯ CIGNA Dental Plus
◯ Willamette Dental of Washington, Inc.

LEVEL OF COVERAGE:
◯ Self Only ◯ Self + One ◯ Self + More Than One
◯ Waive Coverage Covered under HEWT Spouse? ◯ Yes ◯ No
Spouse SSN _____

LAST NAME	FIRST NAME	M.I.	SEX M/F	SOCIAL SECURITY NUMBER	BIRTHDATE MO/DAY/YR	MED (X)	DENT (X)	RELATIONSHIP	COLLEGE STUDENT/ DISABLED
SPOUSE									
CHILD (LEGAL LAST NAME)									S ◯ D ◯
CHILD (LEGAL LAST NAME)									◯ ◯
CHILD (LEGAL LAST NAME)									◯ ◯
CHILD (LEGAL LAST NAME)									◯ ◯

WILL YOU OR ANY OTHER PERSON NAMED ABOVE BE COVERED BY OTHER HEALTH INSURANCE OR MEDICARE? ◯ YES ◯ NO

THE OTHER INSURANCE IS: ◯ GROUP COVERAGE ◯ INDIVIDUAL COVERAGE ◯ MEDICARE PART-A* ◯ MEDICARE PART-B* ◯ MEDICARE PART-D

* NOTE: Group Health participants eligible for Medicare **must** enroll in Medicare Parts A and B.

I hereby apply for enrollment in the plan(s) identified above and authorize my employer to deduct from my earnings the necessary contribution(s), if any, required of me. I understand that services for which I (we) am eligible must be obtained in accordance with the terms of my benefits plan. I hereby authorize any physician, insurer, or other organization or person having any records, data, or information concerning my health history or other insurance for me or my minor dependents, to furnish such records, data, or information as may be requested by the health plan identified above or their duly authorized representative. A copy of this authorization shall be considered as effective and valid as the original.

I hereby authorize my primary insurance carrier to pay the health plan identified directly for services rendered. I understand that I must enroll myself and/or dependents in a health plan within 31 days of becoming eligible, or I must wait for the next regular open enrollment period. I understand contributions are subject to change.

YOUR SIGNATURE X **DATE:**

RETURN to BENEFITS ADMINISTRATION - H2-23. Retain copy for your records.

A-6002-346 (03/06)